K-1. INFANT MEDICAL HISTORY

Infant's last name

First name

For each question indicate who is the source for this information.
Use the Source Code Table placed on the right.

Source Code Table

BP ..... Biological Mother/Father
GP ..... Grandmother/Father
AP ..... Adoptive or Foster Parents
Ph..... Physician
HR..... Health records
O ..... Other (specify)

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

1 In the 72 hours prior to death, was the infant acting different than usual?

☐ No ☐ Yes ⟶ Describe how the infant acted differently:

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

2 In the 72 hours prior to the infant's death, did the infant have:

	Unknown	No	Yes
a) Fever	☐	☐	☐
b) Excessive sweating	☐	☐	☐
c) Lethargy or sleeping more than usual	☐	☐	☐
d) Fussiness or excessive crying	☐	☐	☐
e) Decrease in appetite	☐	☐	☐
f) Vomiting	☐	☐	☐
g) Choking	☐	☐	☐
h) Diarrhea	☐	☐	☐
i) Stool changes	☐	☐	☐
j) Difficulty breathing	☐	☐	☐
k) Apnea (*stopped breathing*)	☐	☐	☐
l) Cyanosis (*turned blue/gray*)	☐	☐	☐
m) Seizures or convulsions	☐	☐	☐
n) Other	☐	☐	☐

Comments

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

3 In the 72 hours prior to death, was the infant injured or did s/he have any other condition(s) not mentioned?

☐ No ☐ Yes ⟶ Please describe:

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

4 At any time in the infant's life did s/he have a history of:

	Unknown	No	Yes
a) Allergies (*food, medication, or other*)	☐	☐	☐
b) Abnormal growth or weight gain	☐	☐	☐
c) Apnea (*stopping breathing*)	☐	☐	☐
d) Cyanosis (*turned blue/gray*)	☐	☐	☐
e) Seizures or convulsions	☐	☐	☐

Comments

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

5 Describe up to 3 most recent times that the infant was seen by a physician or health care provider:
(*Include ER visits, clinic visits, hospital admissions, and observational stays***)**

Please answer the questions for up to 3 ***most recent*** *hospital visits*	First most recent visit	Second most recent visit	Third most recent visit
a) Physician name			
b) Hospital/clinic			
c) Street			
d) City			
e) State, ZIP			
f) Phone number	( )	( )	( )
g) Date	Month / Day / Year	Month / Day / Year	Month / Day / Year
h) Reason for visit			
i) Outcome of visit			

Section K continued on the next page

K-2. INFANT MEDICAL HISTORY

Infant's last name

First name

For each question indicate who is the source for this information.
Use the Source Code Table placed on the right.

Source Code Table

BP ..... Biological Mother/Father
GP ..... Grandmother/Father
AP ..... Adoptive or Foster Parents
Ph ..... Physician
HR ..... Health records
O ..... Other (specify)

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

6 Infant healthcare provider:

First name Last name

Phone ( ) -

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

7 Birth hospital name:

Street

City State ZIP -

Date of discharge / / (Month / Day / Year)

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

8 What was the infant's length and weight at birth?

Inches or cm

lbs ozs or grams

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

9 Compared to due date, was the infant born on time, early, or late?

☐ On time

☐ Early → How many weeks early?

☐ Late → How many weeks late?

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

10 Did the infant have any congenital abnormalities or birth defect(s)?

☐ No ☐ Yes → Describe the congenital anomalies or birth defect(s):

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

11 Was the infant a singleton birth, twin, triplet, or quadruplet or higher gestation?

☐ Singleton birth ☐ Triplet

☐ Twin ☐ Quadruplet or higher gestation

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

12 Were there any complications during delivery or at birth?

☐ No ☐ Yes → Describe complications during delivery or at birth:

Source of information ☐BP ☐GP ☐AP ☐Ph ☐HR ☐O→

13 Are there any alerts to pathologist?

☐ No ☐ Yes → Specify: